

FILED APR 3 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 10626

Registrar's No. 2795

1. PLACE OF DEATH:

- (a) County.....**ST. LOUIS MO**
(b) City or town.....**ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution.....**4053 TOENGES**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....**75 YRS.** (Specify whether years, months or days)

In this community.....
years, months or days

3. (a) PRINT FULL NAME **BARBARA SAUL**

3. (b) If veteran,

name war.....

3. (c) Social Security No.

5. Color or race.....**WHITE**
6. (a) Single, widowed, married, divorced.....**WIDOW**

6. (b) Name of husband or wife.....**THOMAS** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....**MAR 6 1867**
(Month) (Day) (Year)

8. AGE: Years **81** Months **0** Days **15** If less than one day hr. min.

9. Birthplace.....**BOHEMIA**
(City, town, or county) (State or foreign country)

10. Usual occupation.....**WIDOW**

11. Industry or business.....**AT HOME**

12. Name.....**JOHN PEXA**

13. Birthplace.....**BOHEMIA**
(City, town, or county) (State or foreign country)

14. Maiden name.....**ANNA WOPRADSKY**

15. Birthplace.....**BOHEMIA**
(City, town, or county) (State or foreign country)

16. (a) Informant.....**CHARLES SAUL**

(b) Address.....**4053 TOENGES**

17. (a) **BURIAL** (b) Date thereof.....**MAR 24 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....**NEW PICKER CEM.**

18. (a) Signature of funeral director.....**Thomas Kuti & Son**

(b) Address.....**2906 GRAVOIS**

19. (a) **MAR 22 1948** (b) Registrar's signature.....**J. F. Brennan**
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State.....**MISSOURI** (b) County.....**000**
(c) City or town.....**ST. LOUIS** (If outside city or town limits, write "RURAL")
(d) Street No.....**4053 TOENGES** (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No) **0**
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....**MAR.** day.....**21**
year.....**1948** hour.....**11** minute.....**06 A.M.**

21. I hereby certify that I attended the deceased from.....**March 20 48** to.....**March 21 48**
that I last saw him alive on.....**March 21 48**
and that death occurred on the date and hour stated above.

Immediate cause of death.....**Cerebral hemorrhage** Duration.....**26 hrs.**

Due to.....**Cerebral hemorrhage**

Due to.....

Other conditions.....**83**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsies.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?..... (Specify type of place)

While at work?..... (e) Means of injury.....

Signature.....**W. H. Hargreaves** (M. D. or other)

Address.....**4755 Hargreaves** Date signed.....**3/22/48**

PHYSICIAN

Underline the cause of which death should be charged statistically.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
..... Registered Apprentice No.....
working under my personal supervision.

Signed

Leif Budd
Licensed Embalmer No. *3989*

P. O. Address

St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.